TOBACCO USER STATUS CHANGE REQUEST

I am requesting a change in my Tobacco User status.

❒ I completed the Saliva Test for the detection of nicotine presence.
Check one: ❒ Yes ❒ No ❒ N/A

❒ I certify that I and any of my dependents covered under my County-sponsored medical plan **<u>are</u>** **<u>not</u>** Tobacco Users and have not used any tobacco products in the last 6 consecutive months.

❒ I certify that:
- ❒ I **<u>am</u>** a Tobacco User
- ❒ My dependent(s) covered under my County medical insurance plan is a Tobacco User(s).

I understand that a Tobacco User means the occasional or regular use of a tobacco product including cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco.

I certify to the best of my knowledge that the information I have provided is accurate and complete. I understand that I may be subject to disciplinary action, up to and including termination, for failing to provide accurate information. I further understand and agree that I will be required to reimburse Maricopa County for any additional premiums owed as a result of providing inaccurate and/or incomplete information.

Please indicate the date tobacco use ceased. *If you have never used tobacco indicate "Never" in the date field.*	**Date:**
Print Employee Name:	**Date form completed:**
Employee Signature:	**Employee ID Number:** 811_____

Print this page, sign and return to the Employee Benefits Division by fax, mail or in person.

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